Application Month:
_____

RECERTIFICATION
Ryan White Care services
& AIDS Drug Assistance Program (ADAP)

PERSONAL/CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**	**MI:**
Address:		**City:**
County:	**State:**	**Zip Code:**
Mailing address if different from above:		
Phone (H) (____) _____-_____ **(W)** (____) _____-_____ **Cell/Pager** (____) _____-_____		
Emergency Contact/ Legal Guardian: _____ **Phone** (____) _____-_____ **Aware of HIV+ Status:** ☐ **Y** ☐ **N**		
Client Preference for Contact: ☐ phone ☐ phone message ☐ office visit ☐ home visit ☐ mail ☐ email (_____) Can talk to: 1) _____ 2) _____		
Are there any concerns related to the above contacts? If yes, please explain.		

HIV STATUS

Since your last recertification, have you been diagnosed with AIDS? ☐ Yes ☐ No ☐ NA Date of diagnosis: _____/____/_____
Medical Status: Current CD4: _____ (☐Self-Report ☐ Medical Records ☐ Estimated) Date of test: _____/____/_____ Current Viral Load: _____ (☐Self-Report ☐ Medical Records ☐ Estimated) Date of test: _____/____/_____
HIV Care Provider: Name: _____ Phone: (____) _____-_____ Clinic Name: _____ Address: _____

INSURANCE INFORMATION

Do you have private health insurance? □ Yes □ No

If **yes**, is your health insurance through your current or previous employer? □ Yes □ No

If through previous employer, date COBRA Coverage began: _____/_____/_____

If **yes**, does your health insurance cover medications? □ Yes □ No

If **yes**, is there a total expense limit for medications? □ Yes □ No

Name of insurance company: _____

Address: _____

Phone: (____) _____-_____

Group #:_____ Policy #:_____

If no private insurance, what is your insurance status? (proof of insurance required for all)

□ Medicare Part A/AB □ Medicare Part D □ Currently on Medicaid □ VA/ CHAMPUS

□ Applied for Medicaid □ Uninsured □ Other (specify) _____

Date: _____/____/_____

FINANCIAL STATUS & ELIGIBILTY*

Sliding scale only applies to those with no other insurance coverage for services.

Household Size	**Individual Gross Monthly Income: $ _____ Household Gross Monthly Income: $ _____**		**Gross Individual Annual Income: $ _____ Household Gross Annual Income: $ _____**	
1	0– 902	903–1805	1806–2707	2708 & OVER
2	0–1214	1215–2428	2429–3642	3643 & OVER
3	0–1526	1527–3051	3052–4577	4578 & OVER
4	0–1837	1838–3675	3676–5512	5513 & OVER
5	0–2149	2150-4298	4299–6447	6448 & OVER
6	0–2460	2461–4921	4922–7382	7383 & OVER
7	0–2772	2773–5545	5546–8317	8318 & OVER
8	0–3084	3085– 6168	6169–9252	9253 & OVER
Level	**0 – 100%**	**101% - 200%**	**201% - 300%**	**Over 300%**
Eligibility	**Part B and C Eligible**	**Part B and C Eligible**	**Part C Eligible**	
Co-Pay	**$0**	**$10**	**$20**	**$ Pay in Full**
Co-Pay Maximum	**0%**	**5% of Individual Gross Annual $$**	**7% of Gross Individual Annual $$**	**10% of Gross Individual Annual $$**

*** Acceptable proof of income: Pay stubs or bank statements (last 2 months), last year's W2, last year's taxes, SSA Benefit Statement, SSA PEBE Report or Statement of No Income.**

HOUSING STATUS

Most Recent/Current Housing Status:

□ Permanently Housed □ Non-permanently Housed □ Institutionalized

□ Other (specify) _____ □ Unknown

Client Acknowledgement:

As a partner in this process, I acknowledge that:

1) All statements made by me are true to the best of my knowledge (_____).
2) The purpose of my participation in medical case management is to assure my engagement in HIV medical care (_____).
3) I will notify my medical case manager of any change in my health insurance status, financial situation, income, or living arrangements (_____).
4) This program involves the receipt of federal and/or state funds; any person supplying false information is subject to state and/or federal criminal prosecution, which may result in fines, imprisonment, or both. Additionally, there will be an automatic six month suspension from RWPB Programs and ADAP (_____).

_____ _____

Client Signature Date

_____ _____

Case Manager Date